# HOSPITAL FAX REPORTING
# OF INCIDENTS AND ABUSE

GENERAL INSTRUCTIONS:

1. These instructions apply to reporting all hospital incidents, and suspected abuse, neglect, mistreatment and misappropriation of patient property under the Patient Abuse Law.

2. Complete a separate blank form for each occurrence following the instructions below.

3. Use the attached tables to enter a description for those items that are marked "see table."

4. Submit your completed report by fax to the Department immediately for (1) fires; (2) suicide; (3) serious criminal acts; (4) pending or actual strike; (5) serious physical injury or harm to a patient resulting from accident or unknown cause; and, (6) suspected abuse, neglect, mistreatment or misappropriation involving nursing home, rest home, home health, homemaker and hospice patients. **Notify the Department immediately by phone at 617-753-8150 of any deaths resulting from incidents, medication errors, abuse or neglect; and full or partial evacuation of the facility for any reason**. Submit other completed reports within seven days of the date of the occurrence of an incident seriously affecting the health and safety of patients.

5. Fax your completed report to the Department at **617-753-8165**.

LINE BY LINE INSTRUCTIONS

PAGE 1 OF REPORT FORM:

FROM: Please provide the name and address of the facility making the report.

DATE OF REPORT: Enter the date that you are submitting your report to the Department.

*FOR ABUSE, NEGLECT, MISTREATMENT or MISAPPROPRIATION OCCURING IN NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER OR HOSPICE SETTING, NOT AT THE REPORTING HOSPITAL:*

*FACILITY/AGENCY NAME: Indicate the name of the provider at which the suspected abuse, neglect, mistreatment or misappropriation occurred.*

*ADDRESS: Indicate the address (city or town, if street address is not known) of the provider at which the suspected abuse, neglect or misappropriation occurred.*

GENERAL INFORMATION: Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information,

LINE BY LINE INSTRUCTIONS - CONTINUED

and the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

PATIENT INFORMATION: Please provide information here regarding the patient involved. The information reported here should reflect the patient's condition prior to the occurrence. If more than one patient was injured, or if one patient has injured another patient, provide additional patient information under the narrative portion of the report or on an additional page. Please indicate:

NAME: The patient's first and last name.

AGE; SEX; ADMISSION DATE: Enter each for the named patient.

AMBULATORY STATUS: Select the term from Table #1, "Ambulatory Status", that most closely describes the patient's ability to walk.

ADL STATUS: Activities of Daily Living (ADLs) such as eating, dressing or personal grooming. Select the term from Table #2, "Patient ADL Status", that most closely describes the patient's ability to perform these functions.

COGNITIVE LEVEL: Select the term from Table #3, "Patient Cognitive Status", that best describes the patient's cognitive status at the time of the occurrence.

MENTALLY RETARDED/DEVELOPMENTALLY DISABLED: Indicate whether or not the patient is mentally retarded or developmentally disabled. If the resident is either, indicate the name of the Service Coordinator (mentally retarded) or Case Manager (developmentally disabled) assigned to the patient, if known.

REPORT DETAIL:

OCCURRENCE TYPE: Select the term from Table #4, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

TYPE OF HARM: Select the term from Table #5, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.

BODY PART AFFECTED: Use terms such as “arm”, “foot”, etc.; indicate left or right when it applies.

PATIENT’S ACTIVITY AT TIME OF OCCURRENCE: Select the term from Table #6, “Patient’s Activity”, that best describes the patient’s activity at the time of the occurrence. You may select “Other” and describe what happened in one or two words if none of the examples listed are applicable to your report.

PLACE OF OCCURRENCE: Specify where the event occurred. Examples would include: “patient’s room”, “dining room”, “shower room”, or any other short phrase that specifies the type of setting in which the occurrence took place.

WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE: Specify if any equipment was in use, such as “Hoyer lift”, or “walker”.

ANY SAFETY PRECAUTIONS IN PLACE: Check the “yes” or “no”. If “yes”, describe the precautions that were in place.

PAGE 2 OF REPORT FORM:

NARRATIVE: Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

CORRECTIVE MEASURES NARRATIVE: Describe what actions have been taken in response to the occurrence.

NOTIFICATION: Indicate whether or not the patient’s family and physician, and police were notified. Provide the name of the physician notified.

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE: Indicate who was in present and charge at the facility (not on the unit) when the occurrence reported happened.

WITNESS INFORMATION: List the name and title for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in what occurred. Other patients, visitors and volunteers should be listed as witnesses if they have direct knowledge of what occurred.

ACCUSED INFORMATION: When reporting suspected abuse, neglect or misappropriation, indicate the name of the accused, a phone number at which the accused can be contacted, if the accused is a nurse, nurse aide or other licensed professional please indicate the individual’s license or registration number. Check the appropriate block if you are not reporting abuse, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a patient’s money or belongings is unknown. If more than one

individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide, home health aide or homemaker.

REPORTING TABLES:

Table #1: Ambulatory Status:

Independent
Supervised
Dependent/Assist
Wheels Self
Wheelchair
Bedfast
Unknown

Table #2: Patient ADL Status:

Independent
Supervised
Dependent
Unknown
Other

Table #3: Patient's Cognitive Status:

Alert/Oriented
Dementia
Mentally Retarded/Developmentally Delayed
Confused
Alzheimer's
Comatose
Unknown
Other

Table #4: Occurrence Type:

Fall
Abuse
Neglect
Misappropriation
Surgical Error
Medication Error
Accident
Emergency Services
Death
Suicide
Infection Control
Criminal Act
Fire
Pending Strike
Equipment Malfunction
Injury of Unknown Origin
Other (Describe)

Table #5: Type of Harm:

Fracture
Laceration
Bruise/Hematoma
Reddened Area
Dislocation
Burn
Unwelcome Sexual Contact/Advance
Emotional Harm/Upset
Care Not Provided
Quality of Care
Decline in Condition
Infection
Confinement
Property
Funds
Death
No Harm
Other(Describe)
Unknown

Table #6: Patient's Activity

Ambulating
Toileting
Transfer/Assist
Getting Out of Bed
Getting Up From Chair
Reaching
Standing/Sitting Still
Crowded Area
Unknown
Other(Describe)

**HOSPITAL FAX REPORT FORM**

TO: INTAKE STAFF
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE QUALITY
**FAX NUMBER: 617-753-8165**

FROM: Hospital Name: _____
Address (Street): _____
Address (City/Town) _____

DATE OF REPORT: _____ NUMBER OF PAGES: _____

*IF ABUSE, NEGLECT, or MISAPPROPRIATION OCCURING IN **NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER OR HOSPICE** SETTING, NOT THE REPORTING HOSPITAL:*
ABOUT: Facility/Agency Name: _____
Address: _____

GENERAL INFORMATION:
Report prepared by: _____
Title: _____
Phone Number: (_____)_____-_____Ext:_____
Date of Occurrence: Month_____ Date_____ Year_____
Time of Occurrence: _____ am_____ pm_____

PATIENT INFORMATION:
Name: First _____ Last_____
Age: _____
Sex: Male _____ Female _____
Admission Date: Month_____ Date_____ Year_____
Ambulatory Status (See table #1):_____
ADL Status (See table #2): _____
Cognitive Level (See table #3):_____
Mentally Retarded/Developmentally Disabled: ____ Yes ____No.
If yes, Service Coordinator or Case Manager (if known): _____

REPORT DETAIL:
Occurrence Type (See table #4):_____
Type of Harm (See table #5):_____
Body Part Affected: _____ L:____ R: ____
Patient's activity at time of
occurrence (See table #6): _____
Place of Occurrence: _____
What equipment, if any, was being
used at time of occurrence? _____
Any safety precautions in place? Yes_____ No_____
If yes, describe what preventive measures were in place:

[Form continues to page 2.]

REPORTING HOSPITAL: _____ DATE OF OCCURRENCE: _____

NARRATIVE: (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated? [Attach additional pages as needed.] )

Were there any unusual circumstances involved? Yes_____ No_____ If yes, please describe. [Attach additional pages as needed.]

CORRECTIVE MEASURES NARRATIVE: N/A - Incident occurred with another provider _____. (Please address the following: Was there an internal investigation: Yes_____ No_____ If No - why? If yes- What are the investigation findings? What action was taken with regard to: Patient?; Staff?; Facility practice? What is the patient's current status? What corrective action taken regarding equipment involved, if applicable? [Attach additional pages as needed.] )

NOTIFICATION:
Was family notified: Yes_____ No_____
Was MD notified: Yes_____ No_____
Name of MD if notified: _____
Were police notified: Yes_____ No_____

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:
N/A (Incident occurred with another provider):_____
Name: Title: Directly Involved:
_____YES____NO_____

WITNESS INFORMATION: (Check here if unwitnessed: _____)
Name: Title: Directly Involved:
_____YES____NO_____
_____YES____NO_____

ACCUSED INFORMATION: (Check here if unknown or not applicable: _____)
Name: Telephone #:
_____(____)____-_____ AIDE ___; RN/LPN ____
If RN/LPN or other licensed individual, indicate license #:_____